

Rheumatology

enrollment form



Phone: 855-425-4085 Fax: 855-425-4096 ardonhealth.com

Date needed	Medication start date	Ship to: <input type="checkbox"/> Patient <input type="checkbox"/> Physician <input type="checkbox"/> Other:
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Patient information

Patient name	Date of birth	Phone	Alternate phone
Address	City	State	ZIP
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Email	Primary language	Height Weight

Prescriber information

Prescriber name	State License #	NPI #	DEA #
Group or hospital	Address	City	State ZIP
Phone	Fax	Contact person name and phone	

Insurance information: If available, please fax a copy of the prescription and insurance card(s) with this form (front and back).

Clinical

Date of diagnosis	Diagnosis: <input type="checkbox"/> M06.9 Rheumatoid Arthritis <input type="checkbox"/> M08.9 Juvenile Arthritis <input type="checkbox"/> L40.54 Psoriatic Arthritis <input type="checkbox"/> M45.9 Ankylosing Spondylitis <input type="checkbox"/> M46.80 Non-radiographic Axial Spondyloarthritis <input type="checkbox"/> New diagnosis <input type="checkbox"/> Other _____
Previous medications:	Current medications:
<input type="checkbox"/> Acetaminophen, ibuprofen, naproxen, aspirin <input type="checkbox"/> Humira <input type="checkbox"/> Enbrel <input type="checkbox"/> Methotrexate <input type="checkbox"/> Corticosteroids <input type="checkbox"/> Hydroxychloroquine <input type="checkbox"/> Leflunomide <input type="checkbox"/> Sulfasalazine <input type="checkbox"/> Other meds tried: _____	Allergies:
	Has patient had positive TB test? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes, date of last chest x-ray</i> _____
	Is the patient also taking methotrexate? <input type="checkbox"/> Yes <input type="checkbox"/> No
	Is the patient new to therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No
	Is a starter dose needed? <input type="checkbox"/> Yes <input type="checkbox"/> No

Prescription information

Medication	Dose/strength	Directions	Quantity	Refill
<input type="checkbox"/> Actemra®	<input type="checkbox"/> 162 mg/0.9 mL Pen <input type="checkbox"/> 162 mg/0.9 mL Prefilled Syringe	<input type="checkbox"/> Inject 162 mg SUBQ every 14 days <input type="checkbox"/> Inject 162 mg SUBQ every 7 days	<input type="checkbox"/> 2 Pens/PFS <input type="checkbox"/> 4 Pens/PFS	
<input type="checkbox"/> Benlysta®	<input type="checkbox"/> 200 mg/mL Pen <input type="checkbox"/> 200 mg/mL Prefilled Syringe	<input type="checkbox"/> Lupus Nephritis Starter Dose: Inject 400 mg SUBQ every 7 days for 4 doses, then 200 mg every 7 days thereafter <input type="checkbox"/> Maintenance Dose: Inject 200 mg SUBQ every 7 days. <input type="checkbox"/> Lupus Nephritis Starter Dose (pediatrics 15 to < 40 kg): Inject 200 mg SUBQ every 7 days for 4 doses, then 200 mg every 14 days thereafter <input type="checkbox"/> Maintenance Dose (pediatrics 15 to < 40 kg): Inject 200 mg SUBQ every 14 days	<input type="checkbox"/> 8 Pens/PFS <input type="checkbox"/> 4 Pens/PFS <input type="checkbox"/> 4 Pens/PFS <input type="checkbox"/> 2 Pens/PFS	0
<input type="checkbox"/> Bimzelx®	<input type="checkbox"/> 160 mg/mL Pen <input type="checkbox"/> 160 mg/mL Prefilled Syringe	<input type="checkbox"/> Inject 160 mg SUBQ every 28 days	<input type="checkbox"/> 1 Pen/PFS	

Physician signature required

Product substitution permitted	Dispense as written
X _____ Date _____	X _____ Date _____

Ancillary supplies and kits will be provided as needed for administration.

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<input type="checkbox"/> Cimzia®	<input type="checkbox"/> Starter Kit (200 mg/mL Prefilled Syringes)	<input type="checkbox"/> Starter Dose: Inject 400 mg SUBQ at weeks 0, 2, and 4	<input type="checkbox"/> 1 Kit = 6 x 200 mg/mL PFS	0
	<input type="checkbox"/> 200 mg/mL Prefilled Syringe	<input type="checkbox"/> Starter Dose (pediatrics, 20 to < 40 kg): Inject 200 mg SUBQ at week 0, 2, and 4	<input type="checkbox"/> 3 Vials	0
	<input type="checkbox"/> 200 mg Vial	<input type="checkbox"/> Starter Dose (pediatrics, 10 to < 20 kg): Inject 100 mg SUBQ at week 0, 2, and 4	<input type="checkbox"/> 3 PFS	0
		<input type="checkbox"/> Maintenance Dose: Inject 400 mg SUBQ every 28 days		
		<input type="checkbox"/> Maintenance Dose: Inject 200 mg SUBQ every 14 days		
	<input type="checkbox"/> 200 mg/mL Prefilled Syringe	<input type="checkbox"/> Maintenance Dose (pediatrics, 20 kg to < 40 kg): Inject 100 mg SUBQ every 14 days	<input type="checkbox"/> 2 PFS	
	<input type="checkbox"/> 200 mg Vial	<input type="checkbox"/> Maintenance Dose (pediatrics, 10 kg to < 20 kg): Inject 50 mg SUBQ every 14 days	<input type="checkbox"/> 2 Vials	
		<input type="checkbox"/> Other: _____		
		<input type="checkbox"/> Starter Dose (coexistent Psoriasis): Inject 300 mg SUBQ day 1, day 8, day 15, day 22, and then every 28 days starting on day 29	<input type="checkbox"/> 4 Pens	0
		<input type="checkbox"/> Maintenance Dose (coexistent Psoriasis): Inject 300 mg SUBQ on day 29, then every 28 days thereafter	<input type="checkbox"/> 1 Pen	
<input type="checkbox"/> Cosentyx®	<input type="checkbox"/> 300 mg/2 mL Pen	<input type="checkbox"/> Starter Dose (coexistent Psoriasis): Inject 300 mg SUBQ day 1, day 8, day 15, day 22, and then every 28 days starting on day 29	<input type="checkbox"/> 8 Pens/PFS	0
	<input type="checkbox"/> 150 mg/mL Pen	<input type="checkbox"/> Maintenance Dose (coexistent Psoriasis): Inject 300 mg SUBQ on day 29, then every 28 days thereafter	<input type="checkbox"/> 2 Pens/PFS	
	<input type="checkbox"/> 150 mg/mL Prefilled Syringe	<input type="checkbox"/> Starter dose: Inject 150 mg SUBQ day 1, day 8, day 15, day 22, and then every 28 days starting on day 29	<input type="checkbox"/> 4 Pens/PFS	0
		<input type="checkbox"/> Maintenance Dose: Inject 300 mg SUBQ on day 29, then every 28 days thereafter	<input type="checkbox"/> 2 Pens/PFS	
		<input type="checkbox"/> Maintenance Dose: Inject 150 mg SUBQ on day 29, then every 28 days thereafter	<input type="checkbox"/> 2 Pens/PFS	
	<input type="checkbox"/> 75 mg/0.5 mL Prefilled Syringe (pediatric)	<input type="checkbox"/> Starter Dose (pediatrics, 15 to < 50 kg): Inject 75 mg SUBQ day 1, day 8, day 15, and day 22 and then every 28 days starting on day 29	<input type="checkbox"/> 4 PFS	0
		<input type="checkbox"/> Maintenance Dose (pediatrics, 15 to < 50 kg): Inject 75 mg SUBQ on day 29, then every 28 days thereafter	<input type="checkbox"/> 1 PFS	
	<input type="checkbox"/> 50 mg/mL Pen	<input type="checkbox"/> Inject 50 mg SUBQ every 7 days	<input type="checkbox"/> 4 Pens/PFS/ Cart	
	<input type="checkbox"/> 50 mg/mL Prefilled Syringe			
	<input type="checkbox"/> 50 mg/mL Mini Cartridge			
<input type="checkbox"/> Enbrel®	<input type="checkbox"/> 25 mg/0.5 mL Single-dose Vial	<input type="checkbox"/> Pediatrics < 63 kg: Inject 0.8 mg/kg (dose = _____ mg) SUBQ every 7 days	<input type="checkbox"/> 4 PFS/Vials	
	<input type="checkbox"/> 25 mg/0.5 mL Prefilled Syringe	<input type="checkbox"/> Other: _____		
	<input type="checkbox"/> 40 mg/0.8 mL Pen	<input type="checkbox"/> Inject 40 mg SUBQ every 14 days	<input type="checkbox"/> 2 Pens/PFS	
	<input type="checkbox"/> 40 mg/0.8 mL Prefilled Syringe	<input type="checkbox"/> Inject 40 mg SUBQ every 7 days	<input type="checkbox"/> 4 Pens/PFS	
<input type="checkbox"/> Humira®	<input type="checkbox"/> 20 mg/0.4 mL Prefilled Syringe	<input type="checkbox"/> Pediatrics 15 to < 30 kg: Inject 20 mg SUBQ every 14 days	<input type="checkbox"/> 2 PFS	
	<input type="checkbox"/> 10 mg/0.2 mL Prefilled Syringe	<input type="checkbox"/> Pediatrics 10 to < 15 kg: Inject 10 mg SUBQ every 14 days		
	<input type="checkbox"/> 80 mg/0.8 mL CF Pen	<input type="checkbox"/> Inject 80 mg SUBQ every 14 days	<input type="checkbox"/> 2 Pens	
	<input type="checkbox"/> 40 mg/0.4 mL CF Pen	<input type="checkbox"/> Inject 40 mg SUBQ every 14 days	<input type="checkbox"/> 2 Pens/PFS	
	<input type="checkbox"/> 40 mg/0.4 mL CF Prefilled Syringe	<input type="checkbox"/> Inject 40 mg SUBQ every 7 days	<input type="checkbox"/> 4 Pens/PFS	
<input type="checkbox"/> Humira® (Citrate-free)	<input type="checkbox"/> 20 mg/0.2 mL CF Prefilled Syringe	<input type="checkbox"/> Pediatrics 15 to < 30 kg: Inject 20 mg SUBQ every 14 days	<input type="checkbox"/> 2 PFS	
	<input type="checkbox"/> 10 mg/0.1 mL CF Prefilled Syringe	<input type="checkbox"/> Pediatrics 10 to < 15 kg: Inject 10 mg SUBQ every 14 days		
	<input type="checkbox"/> 150 mg/1.14 mL Pen	<input type="checkbox"/> Inject 150 mg SUBQ every 14 days	<input type="checkbox"/> 2 Pens/PFS	
	<input type="checkbox"/> 150 mg/1.14 mL Prefilled Syringe			
<input type="checkbox"/> Kevzara®	<input type="checkbox"/> 200 mg/1.14 mL Pen	<input type="checkbox"/> Inject 200 mg SUBQ every 14 days		
	<input type="checkbox"/> 200 mg/1.14 mL Prefilled Syringe			
<input type="checkbox"/> Olumiant®	<input type="checkbox"/> 1 mg Tablet	<input type="checkbox"/> Take 1 tablet by mouth once daily	<input type="checkbox"/> 30 Tablets	
	<input type="checkbox"/> 2 mg Tablet			

Physician signature required

Product substitution permitted

X

Date _____

Dispense as written

X

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	<input type="checkbox"/> 250 mg Vial (IV use only)	<input type="checkbox"/> Rheumatoid Arthritis Starter Dose (Optional): _____ mg IV x 1 dose, then 125 mg SUBQ every 7 days (start within 24 hours of IV dose) <input type="checkbox"/> Other: _____	<input type="checkbox"/> 1 Vial	
<input type="checkbox"/> Orencia®	<input type="checkbox"/> 125 mg/mL Pen	<input type="checkbox"/> Inject 125 mg SUBQ every 7 days	<input type="checkbox"/> 4 Pens/PFS	
	<input type="checkbox"/> 125 mg/mL Prefilled Syringe	<input type="checkbox"/> Pediatrics 25 to < 50 kg: Inject 87.5 mg SUBQ every 7 days	<input type="checkbox"/> 4 PFS	
	<input type="checkbox"/> 87.5 mg/0.7 mL Prefilled Syringe	<input type="checkbox"/> Pediatrics 10 to < 25 kg: Inject 50 mg SUBQ every 7 days	<input type="checkbox"/> 4 PFS	
	<input type="checkbox"/> 50 mg/0.4 mL Prefilled Syringe	<input type="checkbox"/> Pediatrics 10 to < 25 kg: Inject 50 mg SUBQ every 7 days	<input type="checkbox"/> 4 PFS	
<input type="checkbox"/> Otezla®	<input type="checkbox"/> 75 mg XR Starter Kit <input type="checkbox"/> 30 mg Starter Kit <input type="checkbox"/> 20 mg Starter Kit (pediatrics 20 to < 50 kg)	<input type="checkbox"/> Starter Dose: Take as directed per package instructions	<input type="checkbox"/> 1 Starter Kit	0
	<input type="checkbox"/> 75 mg XR Tablet <input type="checkbox"/> 30 mg Tablet <input type="checkbox"/> 20 mg Tablet (pediatrics 20 to < 50 kg)	<input type="checkbox"/> Maintenance Dose: Take 1 tablet by mouth once daily <input type="checkbox"/> Maintenance Dose: Take 1 tablet by mouth 2 times daily <input type="checkbox"/> Other: _____ Tablets	<input type="checkbox"/> 30 Tablets <input type="checkbox"/> 60 Tablets	
	<input type="checkbox"/> 100 mg Vial	<input type="checkbox"/> Induction: Infuse _____ mg IV at weeks 0, 2, and 6 <input type="checkbox"/> Maintenance Dose: Infuse _____ mg IV every 8 weeks	<input type="checkbox"/> _____ Vial(s)	0
	<input type="checkbox"/> 15 mg XR Tablet <input type="checkbox"/> 1 mg/mL Oral Solution	<input type="checkbox"/> Take 1 tablet by mouth once daily <input type="checkbox"/> Pediatrics ≥ 30 kg: Take 6 mg (6 mL) by mouth 2 times daily <input type="checkbox"/> Pediatrics 20 to < 30 kg: Take 4 mg (4 mL) by mouth 2 times daily <input type="checkbox"/> Pediatrics 10 to < 20 kg: Take 3 mg (3 mL) by mouth 2 times daily	<input type="checkbox"/> 30 Tablets <input type="checkbox"/> 180 mL Bottle	
<input type="checkbox"/> Simponi®	<input type="checkbox"/> 50 mg/0.5 mL Pen <input type="checkbox"/> 50 mg/0.5 mL Prefilled Syringe	<input type="checkbox"/> Inject 50 mg SUBQ once a month	<input type="checkbox"/> 1 Pen/PFS	
<input type="checkbox"/> Skyrizi®	<input type="checkbox"/> 150 mg/mL Pen <input type="checkbox"/> 150 mg/mL Prefilled Syringe	<input type="checkbox"/> Starter Dose: Inject 150 mg SUBQ at week 0 and 4, followed by every 12 weeks thereafter <input type="checkbox"/> Maintenance Dose: Inject 150 mg SUBQ at week 4, then every 12 weeks	<input type="checkbox"/> 1 Pen/PFS <input type="checkbox"/> 1 Pen/PFS	0
	<input type="checkbox"/> 45 mg/0.5 mL Prefilled Syringe	<input type="checkbox"/> Starter Dose: Inject 45 mg SUBQ at weeks 0 and 4, and then every 12 weeks thereafter <input type="checkbox"/> Maintenance Dose: Inject 45 mg SUBQ at week 4, then every 12 weeks thereafter	<input type="checkbox"/> 1 PFS	0
<input type="checkbox"/> Stelara®	<input type="checkbox"/> 90 mg/mL Prefilled Syringe	<input type="checkbox"/> Starter Dose (> 100 kg with coexistent Psoriasis): Inject 90 mg SUBQ at weeks 0 and 4, and then every 12 weeks thereafter <input type="checkbox"/> Maintenance Dose (> 100 kg with coexistent Psoriasis): Inject 90 mg SUBQ at week 4, then every 12 weeks thereafter	<input type="checkbox"/> 1 PFS	0
		<input type="checkbox"/> Starter Dose (pediatrics < 60 kg): Inject 0.75 mg/kg (dose = _____ mg) SUBQ at weeks 0 and 4, and then every 12 weeks thereafter <input type="checkbox"/> Maintenance Dose (pediatrics < 60 kg): Inject 0.75 mg/kg (dose = _____ mg) SUBQ at week 4, then every 12 weeks thereafter	<input type="checkbox"/> 1 Vial	0
	<input type="checkbox"/> 45 mg/0.5 mL Single-dose Vial	<input type="checkbox"/> Psoriatic Arthritis Initiation Dose (coexistent Psoriasis): Inject 160 mg SUBQ week 0, followed by 80 mg week 2, 4, 6, 8, 10, 12 and then every 28 days thereafter <input type="checkbox"/> Psoriatic Arthritis Maintenance Dose (coexistent Psoriasis): Inject 80 mg SUBQ on week 12, then every 28 days thereafter <input type="checkbox"/> Psoriatic Arthritis and Ankylosing Spondylitis Starter Dose: Inject 160 mg SUBQ day 1, followed by 80 mg every 28 days starting on day 29 <input type="checkbox"/> Psoriatic Arthritis and Ankylosing Spondylitis Maintenance Dose: Inject 80 mg SUBQ on day 29, then every 28 days thereafter <input type="checkbox"/> Non-radiographic Axial Spondyloarthritis Dose: Inject 80 mg SUBQ every 28 days	<input type="checkbox"/> 2 Pens/PFS <input type="checkbox"/> 1 Pen/PFS <input type="checkbox"/> 1 Pen/PFS	0
		<input type="checkbox"/> Starter Dose: Inject 100 mg SUBQ at weeks 0 and 4, then every 8 weeks thereafter <input type="checkbox"/> Maintenance Dose: Inject 100 mg SUBQ at week 4, then every 8 weeks thereafter	<input type="checkbox"/> 1 Pen/PFS	0
<input type="checkbox"/> Tremfya®	<input type="checkbox"/> 5 mg Tablet <input type="checkbox"/> 11 mg XR Tablet	<input type="checkbox"/> Take 1 tablet by mouth 2 times daily <input type="checkbox"/> Other: _____	<input type="checkbox"/> 60 Tablets	
		<input type="checkbox"/> Take 1 tablet by mouth once daily	<input type="checkbox"/> 30 Tablets	
	<input type="checkbox"/> 1 mg/mL Oral Solution	<input type="checkbox"/> Pediatrics ≥ 40 kg: Take 5 mg (5 mL) by mouth 2 times daily <input type="checkbox"/> Pediatrics 20 to < 40 kg: Take 4 mg (4 mL) by mouth 2 times daily <input type="checkbox"/> Pediatrics 10 to < 20 kg: Take 3.2 mg (3.2 mL) by mouth 2 times daily <input type="checkbox"/> Other: _____	<input type="checkbox"/> 240 mL Bottle	

Physician signature required

Product substitution permitted

X

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Dispense as written

X

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